DOCUMENT RESUME

ED 453 330 UD 034 205

AUTHOR	Ku, Leighton; Freilich, Alyse
TITLE	Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston.
INSTITUTION	Henry J. Kaiser Family Foundation, Washington, DC.
SPONS AGENCY	Office of the Assistant Secretary for Planning and Evaluation (DHHS), Washington, DC.; Health Care Financing Administration (DHHS), Washington, DC.; Administration for Children and Families (DHHS), Washington, DC.; Food and Nutrition Service (USDA), Washington, DC.; Economic Research Service (USDA), Washington, DC.; Immigration and Naturalization Service (Dept. of Justice), Washington, DC.
PUB DATE	2001-02-00
NOTE	36p.; Supported by the Kaiser Commission on Medicaid and the Uninsured.
AVAILABLE FROM	Henry J. Kaiser Family Foundation, 1450 G Street, N.W., Suite 250, Washington, DC 20005. Tel: 202-347-5270; Fax: 202-347-5274. For full text: http://www.kff.org.
PUB TYPE	Reports - Research (143)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Child Health; Federal Legislation; *Health Insurance; *Health Services; Hospitals; *Immigrants; *Immigration; Local Government; Low Income Groups; Public Policy; Urban Areas
IDENTIFIERS	California (Los Angeles); Childrens Health Insurance Program; Florida (Miami); Medicaid; New York (New York); State Policy; Texas (Houston); *Welfare Reform

ABSTRACT

This report assesses how the loss of Medicaid coverage following welfare reform has influenced changes in health care systems for immigrants in four urban areas: Los Angeles, California; New York, New York; Houston, Texas; and Miami, Florida. Survey data indicate that over half of low-income immigrants were uninsured in 1998, a level roughly double that of the native citizen population. Visits to each area in 1999-00 examined immigrants' access to insurance and health care services, changes in state and local policies and practices, and responses of local providers and agencies. All four areas have large health care safety nets, anchored by locally owned public hospitals and clinics. These public facilities were dominant providers of care for low-income immigrants, regardless of insurance status. In each area, states also elected to provide some additional coverage to immigrant children under the State Children's Health Insurance Program (S-CHIP). In some areas, outreach campaigns encouraged ethnic and immigrant parents to enroll their children in S-CHIP. Low-income immigrants' access to health care services was precarious before welfare reform and has weakened since then. Though many immigrants have turned to safety net providers offering free or reduced price care, they have also delayed or avoided medical care and turned to alternative, sometimes underground, health care providers for services. State and local government actions and safety net providers have cushioned the effects of federal policy changes, but such efforts may not be sustainable as the number of immigrants ineligible for Medicaid grows. (Contains 32 references.) (SM)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 453 330

kaiser commission on medicaid and the uninsured

Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston

Prepared by
Leighton Ku
and Alyse Freilich
The Urban Institute
Washington, DC

February 2001

BEST COPY AVAILABLE

THE HENRY J. KAISER FAMILY FOUNDATION

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

M. James
Henry J. Kaiser Family Foundation

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

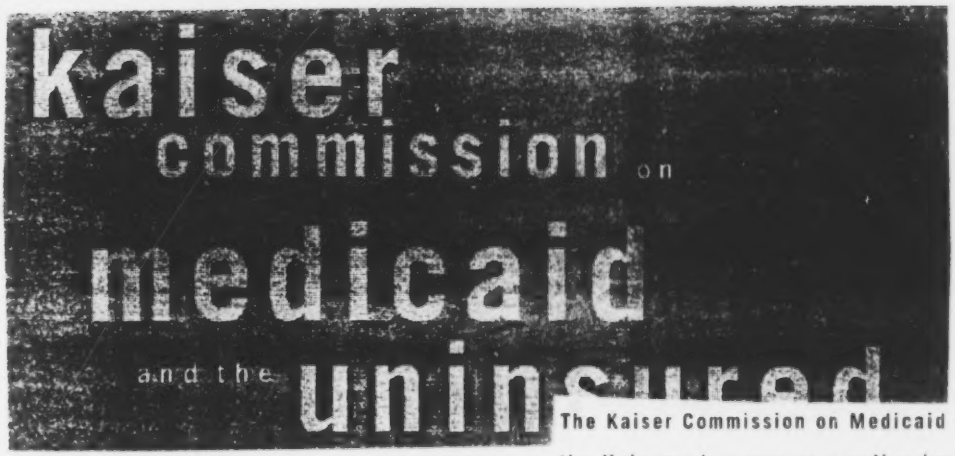
U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

UD034205



The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of the Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

James R. Tallon
Chairman

Diane Rowland, Sc.D.
Executive Director

BEST COPY AVAILABLE

kaiser commission on medicaid and the uninsured

Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston

Prepared by
Leighton Ku
and Alyse Freilich
The Urban Institute
Washington, DC

February 2001

THE HENRY J. KAISER FAMILY FOUNDATION

ACKNOWLEDGEMENTS

The writing of this paper and the case study site visits to Miami and Houston were supported by The Kaiser Commission on Medicaid and the Uninsured. Data collection and site visits to New York City and Los Angeles were supported by a cooperative agreement funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Health Care Financing Administration, the Administration for Children and Families (all of the U.S. Department of Health and Human Services), the Food and Nutrition Service and the Economic Research Service (both of the U.S. Department of Agriculture), and the Immigration and Naturalization Service (U.S. Department of Justice). Michael Fix and Grant Miller of the Urban Institute participated in the site visits and provided invaluable comments and advice on this paper. Dozens of local and state officials, hospital and clinic administrators, physicians, nurses, advocates, community service providers, and other experts patiently gave of their time and effort to help us understand the circumstances in the four cities. We were grateful for guidance and advice from the two project officers, Julie Hudman of The Kaiser Commission on Medicaid and the Uninsured, and David Nielsen of ASPE, and other federal officials, including Lorna Aldrich, Julia Paradise, Lisa Roney, and Caroline Taplin.

THE AUTHORS

At the time this report was drafted, Leighton Ku and Alyse Freilich, were both on the staff of the Urban Institute. Dr. Ku is now at The Center on Budget and Policy Priorities and Ms. Freilich works at The Advisory Board Company.

TABLE of CONTENTS

Executive Summary i
A. Introduction 1
B. Background on the Four Cities 3
C. Immigrants' Access to Medicaid and S-CHIP 7
D. Immigrants' Access to Health Services 12
E. Safety Net Providers' Organizational and Financial Responses 17
F. Factors Shaping the Policy Responses in the Four Cities 20
G. Conclusions 22
References 23

List of Tables

1. A Profile of Immigrants in Four Cities 3
2. Summary of Medicaid and S-CHIP Eligibility for Noncitizen Children, as of August 2000 10

EXECUTIVE SUMMARY

Even in the early 1990s, immigrants had challenges obtaining access to health care services in the United States because of their poverty, high levels of uninsurance, as well as their language and cultural differences. During the late 1990s, immigrants' access to health care services became even more problematic, as immigrants began to lose Medicaid coverage, due to the 1996 federal welfare reform law which barred immigrants entering the U.S. after August 1996 from participating in Medicaid, and other policy changes that discouraged participation by eligible immigrants and by U.S.-born children of immigrants. The purpose of this report is to assess how these and related factors influenced changes in the health care systems for immigrants in four urban areas with large immigrant populations: Los Angeles, California; New York, New York; Houston, Texas; and Miami, Florida.

In late 1999 and early 2000, we conducted case study site visits to each area and met with clinic and hospital administrators, doctors and nurses, local Medicaid and health officials, community-based organizations and immigration and health experts and advocates. The purpose of our visits was to understand immigrants' access to insurance and health care services, changes in state and local policies and practices and the response of local providers and agencies immigrant-related policy changes.

Background About the Four Cities. Los Angeles, New York City, Miami, and Houston all have large immigrant populations. Collectively, they have 9 million foreign-born residents, of whom almost 6 million are noncitizens. Each city has a distinctive ethnic blend; for example, Los Angeles' and Houston's immigrants are primarily from Mexico, Central America or Asia, while New York also has large Caribbean and Eastern European populations and Miami is dominated by Caribbean and Central American immigrants. But, in each area the population of noncitizen immigrants is disproportionately poor and uninsured, compared to native citizens in those areas.

All four urban areas have large health care safety nets, anchored by locally-owned public hospitals and clinics. In each city, these public facilities were dominant providers of care for low-income immigrants, whether they had Medicaid or were uninsured. Immigrants also received care at charitable hospitals and clinics in these cities, although the nonprofit safety nets were smaller in Houston and Miami.

Immigrants' Access to Medicaid and the State Children's Health Insurance Program (S-CHIP). National survey data show that Medicaid participation by low-income immigrants and their citizen children fell and their uninsurance rates climbed since the 1996 welfare reform law was passed. However, the most recent Census data indicate that the situation might have begun to reverse between 1998 and 1999 and that immigrants' use of Medicaid rebounded somewhat. In all the cities, health care providers and local officials stated that the number of immigrants with Medicaid coverage had fallen sharply since 1996, although they often could not document this. (Most Medicaid and medical data systems did not indicate whether enrollees or patients were immigrants, so trend data were not available.) Data from Los Angeles County indicated that the number of noncitizen immigrants and their children on Medicaid fell more than 50 percent between 1996 and 1998, but some believed it had begun to climb again since then.

Key reasons cited for the loss of Medicaid coverage included both the actual changes in immigrants' eligibility, as well as fears that participating in Medicaid could have adverse consequences for a person's or family's immigration status (e.g., be unable to get a green card or to reenter the United States after travelling abroad). The worries about the use of Medicaid appeared to be the most severe in Los Angeles, perhaps because there had been a long-running political debate about immigrants' use of public benefits, but the fears cropped up in every community. Our site visits took place after the Immigration and Naturalization Service issued guidance clarifying that receipt of Medicaid (except long-term care) would not count in determining "public charge" status. Despite public education and outreach campaigns trying to emphasize that getting Medicaid or S-CHIP would not endanger immigration status, many immigrants still had misgivings or were confused about the rules. New worries were being expressed concerning the recently adopted Affidavits of Support and the notion that immigrants' sponsors might be billed for their Medicaid expenses.

State governments tried to cushion the loss of health insurance coverage, particularly for children, by using state funds to supplement their federally-funded programs.[1] In each state, recent immigrant children were eligible for S-CHIP coverage through state-funded add-ons, although Florida recently limited the number who could participate. California had developed the most inclusive policies and developed state-funded add-ons to its Medicaid and S-CHIP programs so that all recent immigrants were still fully eligible for insurance coverage. Thus, changes in immigrants' Medicaid participation in California were not due to tightened eligibility criteria, per se, but due to other factors like worries over the public charge issue and confusion about the state's rules.

Immigrants' Access to Health Services. Survey data indicate that over half of low-income immigrants are uninsured, a level roughly double that of the native citizen population. Thus, immigrants are particularly reliant on safety net health care providers, like public and nonprofit hospitals and clinics, that offer free or reduced-price health care. Immigrants also avoided treatment, delayed care and used alternative—sometimes underground—sources of care. For example, some immigrants sought care from lower cost unlicensed health care providers, sometimes folk medicine providers, and many bought prescription drugs smuggled in from abroad, because of their inability to get prescriptions and because of the high costs of drugs.

In every city, language difficulties faced by immigrants with limited English capabilities were viewed as a major barrier to medical care and serious threat to medical care quality. Although there were many health care providers who speak Spanish or who have bilingual staff, Spanish-speaking immigrants often could not communicate with their doctors or nurses. Immigrants who spoke other foreign languages, such as Vietnamese, Khmer, Creole, Russian and other languages, had greater difficulties with interpretation and translation services. The inability to communicate with health care providers not only limited immigrants' access to care, but threatened the quality of medical services since clinicians could not get information to make good diagnoses and because patients might not understand the treatment regimens prescribed for

[1]Under federal law, immigrants who entered the United States after August 1996 are not eligible for full Medicaid or S-CHIP coverage, but the costs of emergency care provided under Medicaid can be covered. States can opt to use state funds—without federal matching funds—to add-on nonemergency coverage to either S-CHIP or Medicaid coverage for these recent immigrants.

them. Finally, some immigrants felt that health care providers and some welfare agencies treated them rudely or disrespectfully because of their language difficulties or ethnic backgrounds.

Access problems appeared to be the most severe for undocumented aliens who, in addition to the above-mentioned problems, also feared that government institutions might report them to the Immigration and Naturalization Service and who were sometimes completely ineligible for subsidized services. For example, at the time of our visits, the main public hospital systems in Houston and Miami would not provide locally-subsidized health care services to undocumented aliens, although the policies appear to have broadened since our visits.

For immigrants who retained coverage, Medicaid managed care could be quite confusing. Immigrants often did not understand managed care plan and primary care provider choices and often were assigned to unfamiliar health care providers who did not speak their languages or know their medical histories. In many cases, immigrants did not get informational materials in their languages. There were also cultural misunderstandings because the requirements of managed care were so much more complicated than the health care systems that they were familiar with in their home countries.

Safety Net Providers' Organizational and Financial Responses. In each area, the core public safety net providers reported that they were losing Medicaid patients and revenue, while the number of uninsured patients were rising. Immigrant eligibility changes were just one part of broader array of difficulties, such as broader reductions in Medicaid caseloads, new requirements under Medicaid managed care and general competition in the health care arena. Facilities were shifting resources to try to hold down expenses while also looking for new revenue streams. Thus, there was often increased competition for the remaining Medicaid clientele and the new S-CHIP enrollees.

Analyses of data from New York indicated that hospitals in high immigrant areas faced greater problems with bad debt and uncompensated care and higher growth in the uninsured patient load. Birth data from Los Angeles indicated that the number of deliveries paid by Medicaid fell twice as rapidly for foreign-born mothers as for native-born mothers.

In some cases, the loss of Medicaid revenue was at least partially offset by new revenue sources. For example, Los Angeles' Public Private Partnership program (funded under a Medicaid Section 1115 waiver) was helping nonprofit clinics pay for care for low-income uninsured patients, many of whom were immigrants. Similarly, the expansion of New York's S-CHIP program, Child Health Plus, was also helping to ensure that immigrants' children were still getting insurance coverage.

Despite these problems, in each community there were also innovative attempts to improve services for immigrants. For example, Medicaid managed care contracts in New York added requirements for language accessibility and encouraged the use of services like AT&T Language Line or similar telephone-based interpretation services where applicable. In Houston, a Catholic hospital system developed a mobile van to improve access to preventive services for hard-to-reach people, especially immigrants, in the community. In Los Angeles, community groups had developed a small insurance network for low-income immigrants. In many cases, community service organizations were partnering with health clinics or hospitals to improve outreach and translation services.

Factors Shaping the Policy Responses. The loss of federal Medicaid and S-CHIP funding for recent immigrants effectively meant that state and local governments must bear heavier responsibilities in determining whether to cover the gaps left by the change in federal policies. Each of these four states opted to cover recent legal immigrant children in their S-CHIP programs, although Florida recently decided that it was not going to cover any more of them unless federal matching funds were available.

California made the broadest commitment to continue to provide full Medicaid and S-CHIP coverage to recent immigrants, using state-funded add-ons. This policy action may seem somewhat paradoxical because California was also the state with the most visible and contentious policy debate concerning immigrants, particularly under the administration of former Governor Wilson. The other three areas had more inclusive political rhetoric, but did not extend any state-funded Medicaid coverage for recent immigrants. One possible explanation is that the controversy generated by the public debate in California helped coalesce immigration advocates in that state to generate the political will to enact the broad policies, while the lower level of conflict or controversy in the other three states made it difficult to do anything but accept the federal default policies.

In each area, the policies were not entirely shaped by monolithic government decisions, but were also influenced by local advocacy groups and by the interplay of state and local policies. Advocates used education, persuasion and sometimes litigation to broaden immigrants' services. Local governments sometimes took special efforts to help support immigrants' insurance eligibility, knowing that they would otherwise bear much of the cost of uncompensated care through their public hospitals and clinics.

A final important element was the traditional strength of the health and social safety nets in each area. New York and California are more affluent states with deeper safety net capacity, so that Los Angeles and New York City could more readily absorb the additional responsibilities for the care of uninsured immigrants than Houston or Miami. While Medicaid offers greater federal support in low-income areas, through the design of the Medicaid matching rate, additional health care responsibilities that must be financed outside of Medicaid can pose more difficulties in lower-income areas.

Conclusion. Low-income immigrants' access to health care services was precarious before welfare reform was enacted and has weakened since then. There have been numerous responses to the loss of Medicaid coverage. Immigrants appear to have shifted care increasingly toward safety net providers that can offer free or reduced-price care, but have also delayed or avoided medical care and turned to alternative, sometimes underground, health care providers for services.

The actions of state and local governments and safety net providers cushioned the effects of the federal policy changes; they bore additional responsibilities and costs. These state and local efforts might not be sustainable. With time, the number of immigrants who arrived after 1996 and who are ineligible for Medicaid will grow. Some state and local economies are showing signs of weakening after many years of economic growth. It is not clear whether they will be able to continue these policies, much less improve upon them. In addition to insurance eligibility and health care financing issues, there are many other issues—like language and outreach services—that can be equally important in ultimately affecting immigrants' access to health care.

A. Introduction

In the 1990s, a series of federal and state policy actions limited immigrants' access to public benefits, including Medicaid and other health insurance coverage. California's Proposition 187 sought to prohibit the use of state funds for undocumented (illegal) aliens' public benefits, including prenatal care. Later, a series of well-publicized enforcement activities sought to force immigrants to repay their Medicaid benefits to avoid being determined a "public charge" and jeopardizing their U.S. residency status. The policies created a "chilling effect" in which many low-income immigrants feared that applying for benefits (for themselves or their families) might endanger their legal status.

In 1996, the Personal Responsibility and Work Opportunities Reconciliation Act (PRWORA) and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) restricted immigrants' eligibility for Medicaid and other benefits by imposing a five-year bar on full Medicaid eligibility for non-refugee immigrants entering the U.S. after August 1996 when the law was passed (hereafter, called "post-enactment immigrants"). Furthermore, the income of immigrants' sponsors should now be counted in determining eligibility and sponsors may be held financially liable for public benefits used by the immigrants (Zimmermann and Tumlin 1999). The confluence of these policies created confusion about eligibility for benefits and appeared to lead many, even those eligible, to believe that they should simply avoid public programs.

What is the "Public Charge" Issue?

Under immigration law, a person may be barred from entering the United States or adjusting from temporary to permanent resident status if the government determines that he or she is likely to become a "public charge." Historically, getting Medicaid was not a factor in determining public charge status, unlike the receipt of cash welfare. In the mid-1990s, there were a number of well-publicized cases in which immigrants seeking to reenter the country were told by Immigration and Naturalization Service (INS) or State Department consular officials that they had to repay Medicaid benefits to avoid being considered a public charge (Schlosberg and Wiley 1998).

For example, one California clinic administrator told the story of a patient who visited China to show her baby girls to her family. Upon returning to the U.S., she was told that she had to repay several thousand dollars in Medicaid bills related to the delivery of her daughters or she could not reenter the U.S. She did not have the money. Citizen relatives came to the airport to take care of the girls (who were U.S.-born and therefore citizens) in the U.S., but the mother was sent back to China. The mother has not seen her children since that time.

Similar stories spread and sometimes were exaggerated, causing alarm in immigrant communities. In 1999, the INS issued guidance that getting Medicaid (except for long-term care) or noncash benefits like food stamps or WIC vouchers would not be used in determining public charge status relating to issues of permanent residence. Public charge status is not supposed to be used in determining whether a person is qualified to become a citizen.

Although low-income immigrants already had high uninsurance rates and relatively low participation in Medicaid in the early 1990s, the latter part of the 1990s saw even further declines in Medicaid coverage and increasing uninsurance rates (Zimmermann and Fix 1998; Brown, et al. 1999; Fix and Passel 1999; Ku and Matani 2001; Holahan, Ku and Pohl, 2001). The data also show that U.S.-born children of immigrants' Medicaid coverage fell during this period, even though they continued to be eligible. Immigrants' access to insurance and to health care has been far below that of similar low-income native citizens and their children (Ku and Matani 2001).

This paper examines the consequences of these policy changes from a case study perspective. We conducted "street-level" research, talking with health care providers, advocates, government officials and other experts in four cities with high immigrant populations: Los Angeles, New York City, Miami, and Houston. Not only do these cities have large immigrant populations, they also include a range of economic and policy environments. In late 1999 and early 2000, two person teams spent three to seven days in each city, meeting with physicians, nurses, clinic and hospital administrators, local government officials, community-based organizations, advocates and experts. Another report (Freilich, et al. 2001) provides more detailed information about New York City and Los Angeles, while this one integrates information from all four cities. This report complements other qualitative research about immigrants and health care by Maloy and her colleagues (2000) and by Feld and Power (2000).

The focus of our inquiry was how immigrant policy changes affected the health care safety net in these four urban areas. By the safety net, we mean the system of care for low-income and uninsured patients provided by certain public and nonprofit clinics and hospitals (Lewin and Altman 2000). Safety net providers typically include public hospitals, nonprofit charitable hospitals, local health departments, community health centers, free clinics and similar facilities. Typically, these providers serve a disproportionate share of Medicaid clients and provide uncompensated care for uninsured people, using public and private grants and other revenue sources (e.g., special property taxes for health care districts) to underwrite the care.

Because of their locations in high-immigrant areas and commitment to serve needy immigrants, many safety net providers have developed special capabilities, such as bilingual staff, interpreter services, and special culturally-adapted programs. But therein lies the rub: by developing expertise to serve immigrants, these providers could be more susceptible to reductions in Medicaid coverage or increases in the demand for uncompensated care by immigrants.

Through our case studies of four cities, conducted in late 1999 and early 2000, we addressed these policy issues:

- Did immigrants' access to Medicaid change and why? What was the role of State Children's Health Insurance Program (S-CHIP) in each state?
- What problems did low-income immigrants face in accessing health services? Were there differences for legal and illegal immigrants? Has Medicaid managed care affected immigrants?
- How have these changes affected health care providers, both financially and organizationally?
- What factors affected the policy responses in the four cities?

B. Background on the Four Cities

Table 1 provides a demographic profile of the cities. Los Angeles and New York City have the most immigrants, but both Miami and Houston also have large immigrant populations. Each area has relatively high poverty and uninsurance rates for the general population, but the level of poverty among noncitizen immigrants is strikingly higher. Compared with the general population, noncitizens have more poverty (ranging from 34 to 41 percent below poverty), more uninsurance (from 42 to 60 percent) and less Medicaid (8 to 17 percent). Houston and Los Angeles had the highest levels of uninsurance; in both cities, a majority of noncitizens have no insurance.

Table 1
A Profile of Immigrants in Four Cities

	Los Angeles County	New York City	Dade County (Miami)	Houston Area
Total Population (in millions)	10.07	11.63	3.77	4.16
Percent of Population Foreign Born	35%	28%	31%	18%
Number Foreign Born (in millions)	3.52	3.26	1.17	0.75
Percent of Population Noncitizen	25%	18%	18%	12%
Number Noncitizens (in millions)	2.52	2.09	0.68	0.50
AMONG TOTAL POPULATION:				
Percent Below Poverty	27%	26%	20%	20%
Percent Nonelderly Uninsured	30%	24%	22%	31%
Percent Nonelderly with Medicaid	15%	19%	11%	8%
AMONG NONCITIZENS:				
Percent Below Poverty	41%	35%	34%	35%
Percent Nonelderly Uninsured	55%	46%	42%	60%
Percent Nonelderly with Medicaid	13%	17%	13%	8%
Top Ten Foreign Countries of Birth (in descending order)	Mexico	Dominican Rep.	Cuba	Mexico
	El Salvador	Mexico	Nicaragua	Vietnam
	Guatemala	Russia	Haiti	El Salvador
	Philippines	China	Colombia	India
	Korea/S. Korea	Jamaica	Dominican Rep.	Pakistan
	China	Guyana	Honduras	Guatemala
	Vietnam	Trinidad/Tobago	Venezuela	Nigeria
	Iran	Ecuador	Jamaica	China
	Taiwan	India	Mexico	Dominican Rep.
	Russia	Haiti	Peru	Cambodia

All data are based on Urban Institute tabulations of Current Population Surveys and are averages for March 1997, 1998, and 1999. Insurance and poverty status are measured for the year before the survey, so they represent the average status in 1996–98.

Each city's immigrant population has a distinctive blend of national origins. Mexicans are the leading immigrant group in Los Angeles and Houston and the second largest group in New York City, but they are less numerous in Miami. Dominicans, other Caribbean groups, and Russians are primary immigrant groups in New York City, while Cubans are the largest group in Miami. Central Americans are numerous in Los Angeles, but not in New York. Asian immigrants are relatively plentiful in Los Angeles and Houston, but are not among the top groups in Miami.

In order to understand the answers to the research questions, a brief introduction to the health and policy environment of each city is important.

Los Angeles County. The key safety net provider in Los Angeles is the county's Department of Health Services, which administers public hospitals, public clinics and the public health system, including the LAC/USC Medical Center, one of the largest public hospitals in the nation. The department provides about 95 percent of inpatient care for the uninsured and 30 percent of all Medicaid services. In addition, the county is home to many community health centers, free clinics and nonprofit hospitals that also provide safety net services. Under a special federal Medicaid waiver, the county is trying to restructure its health system to decrease reliance on hospitals and to increase use of outpatient services. The county has developed a "Public Private Partnership" system in which private clinics receive funds from the county to provide outpatient services for uninsured low-income people, even if they are not Medicaid-eligible (Long and Zuckerman 1999; Los Angeles Co. Dept. of Health Services 1999).

Los Angeles' health care market includes a number of for-profit clinics ("clinicas") that serve uninsured immigrants on a cash or credit payment basis. Several informants speculated that some of these clinics offered substandard quality of care and that the staff were not always licensed to practice. However, some felt they filled an important niche by serving a population that is less comfortable going to regular clinics. Even a for-profit hospital specializing in immigrants was being planned with the expectation that a high proportion of the care would be self-paid (i.e., uninsured) on a cash or credit basis.

Immigrant-related policies were very divisive and visible in southern California. On one hand, the California electorate passed Proposition 187 in 1994 and the state collaborated with the Immigration and Naturalization Service (INS) to force immigrants to repay Medicaid benefits based on "public charge" issues. On the other hand, California became one of the most generous states in the nation by providing state-funded add-ons to Medicaid and food stamps for post-enactment immigrants (Zimmermann and Tumlin 1999).[2] California uses state-only funds for nonemergency services, while emergency services are still federally-matched under Medicaid. Further, for many years the state has permitted undocumented aliens to enroll in Medicaid, signing up for emergency-only benefits, while most states will only enroll them after an emergency occurs.

---

[2]Throughout the balance of this report, we use the term "state-funded add-ons" to describe state programs that extend Medicaid or S-CHIP coverage to post-enactment immigrants, beyond the range permitted by federal law. These programs use federal and state funding for emergency services, but use state funds—without federal matching payments—for non-emergency services provided to the immigrants. In most respects, the state-funded add-ons function like parts of the Medicaid or S-CHIP programs, although the sources of funding differ.

New York City. The New York City Health and Hospitals Corporation administers several public hospitals and clinics and provides about half of all ambulatory health care visits for uninsured people (Prinz et al. 2000). Community health centers and nonprofit hospitals also serve as safety net providers.

Immigrant policies were less volatile and visible in New York than Los Angeles. When PRWORA was passed, Mayor Giuliani protested the exclusion of benefits for immigrants. Nonetheless, New York has not enacted any special provisions to provide state funding for those losing federal Medicaid benefits. Even a subsequent law expanding Medicaid coverage for families still excludes post-enactment immigrants. The key exception is that the state provides prenatal care to women, regardless of immigration status, under the mandate of a court ruling *(Lewis v. Grinker)* that predated PRWORA.[1] (There is ongoing litigation regarding immigrants' benefits in New York; this paper reflects current policies, as we understand them.) Although the political rhetoric in New York has been less adversarial about immigrants than in California, their Medicaid eligibility policies are actually more restrictive.

Miami (Dade County). The key safety net provider in Miami is Jackson Memorial Hospital (JMH), which administers the Public Health Trust, a revenue source derived from a dedicated property tax. JMH is the nation's largest public hospital. Several county health department clinics, a few nonprofit community health centers and some nonprofit hospitals (e.g., Homestead Hospital) also serve as safety net providers. The safety net resources outside the public system are limited, however. A controversial issue during our visits was the extent to which JMH would share Public Health Trust funding with other health care providers, particularly community health centers serving areas further away from the hospital. JMH is relatively unusual among safety net providers; it has continuously maintained a positive financial balance, in large measure due to the generosity of Public Health Trust funds. In May 2000, the state legislature passed a bill to shift some of the funds to other local hospitals to help develop a managed care program for the indigent.

Like New York, Florida had relatively little anti-immigrant rhetoric, but the state did not enact any special programs for noncitizens losing Medicaid eligibility under PRWORA. One Florida official told us that in 1997 the need for special provisions was considered less pressing because Cubans and Haitians, two of the large immigrant groups in Miami, received special exemptions as refugees under the federal legislation and could still get Medicaid. Historically, the state's non-Medicaid child health insurance program (Healthy Kids) served noncitizen immigrant children, but in June 2000 the state decided to stop offering eligibility to noncitizen children who entered after August 1996 and were not eligible for federal matching funds, although they would continue to serve the noncitizen children already enrolled.

Houston (Harris County). The key safety net provider in Houston is the Harris County Hospital District, which oversees three public hospitals and several community health centers. Like Miami, the hospital district gets local funding from a special property tax. The health

[1] However, both New York state and the federal government have sought to overturn *Lewis v. Grinker.*

departments of the city of Houston and of Harris County also operate clinics, primarily offering maternal and child health and preventive services. Safety net care is also provided by some nonprofit hospitals and affiliated clinics (particularly the Sisters of Charity/Christus system). However, there are no federally funded community health centers in the city of Houston. The status of the safety net assumes even greater importance in Houston than in the other cities because it has the highest uninsurance rates and lowest Medicaid coverage.[4]

While not receiving as much attention as Los Angeles, some public charge enforcement activities for Medicaid also occurred in Texas, so its immigrant community was wary about participating in Medicaid. Like Florida, there was little anti-immigrant political rhetoric in Texas, but the state excludes post-enactment immigrants from Medicaid coverage and has no special state programs to provide supplemental benefits.

[4]Much of this is because Texas' Medicaid eligibility criteria have historically been among the least generous in the nation (Rajan 1998; Spillman 2000).

C. Immigrants' Access to Medicaid and S-CHIP

More than half of the low-income (below 200 percent of poverty) noncitizen immigrants in the United States were uninsured in 1998, a level roughly double that of low-income native citizens (Holahan, Ku and Pohl 2001). Analyses of the March 2000 Current Population Survey indicate that Medicaid participation by low-income immigrants and their U.S.- and foreign-born children increased slightly between 1998 and 1999, although 1999 participation levels were still lower than those of 1995, the year before the welfare reform law was enacted (Ku and Blaney 2000). In analyses of survey data (Ku and Matani 2001), we found that noncitizens and their children (including citizen children) participated in Medicaid less than similar native citizens and their children, even after using statistical adjustments to control for differences in income, health status, race/ethnicity, employment and education. This case study enriches our understanding of problems faced by immigrants, as witnessed by local providers, officials and advocates.

Medicaid. In each city, there was broad consensus that the number of noncitizen immigrants on Medicaid had fallen since 1995, but this trend could only be documented in Los Angeles. Even though California retained full Medicaid eligibility for post-enactment immigrants, the number of noncitizen immigrants and their children applying for Medicaid fell more than 50 percent after the passage of the federal welfare reform law (Zimmermann and Fix 1999). During the site visit, we heard that caseloads had climbed back somewhat since then. In the other cities, data were not available because (1) immigration status was not included in Medicaid data systems because it was not an eligibility criterion in earlier times and (2) local agency staff were generally unaware of participation trends since data analysis was not conducted at the local level. Due to this lack of data, it is hard to determine if Medicaid participation of noncitizen immigrants changed more in one city than another.

Various explanations for the changes in immigrants' Medicaid participation were cited. In all the cities, we heard that immigrants were afraid to apply for Medicaid (or other public benefits) because it might endanger their residency status in the U.S., cause them to be deported, or have to be repaid. This "chilling effect" was compounded by a common, erroneous belief that welfare reform meant that most immigrants were not eligible for benefits anymore. The public charge fears appeared to be greatest in California, where the public charge enforcement activities were most visible. Immigrants were often acting on the advice of immigration lawyers or "notarios."[7] Many immigrants were advised (or misadvised) that if they ever wanted to adjust their status (e.g., shift from a visa status to permanent residency or from residency to citizenship) or to sponsor the admission of relatives, it was safer to avoid public programs because that might be adversely viewed by the INS.

Our site visits occurred after the March 1999 issuance of INS guidance on the public charge issue. In each area, community organizations, sometimes aided by public agencies, conducted public education about the new public charge rules. The education efforts appeared strongest in Los Angeles, where the fears were the highest. It is hard, at this point, to judge the efficacy of education efforts since many immigrants have deeply rooted misgivings about the INS. For

[7] "Notarios" provide advice about immigration issues in the community. In some cases they were lawyers in their home countries, but are not licensed to practice law here. They often are certified as notaries public, but also provide legal advice.

example, although Los Angeles County officials held a televised press conference publicizing the new public charge rules, one immigrant attending said she understood the new rules, but still did not plan to apply for Medicaid, explaining, "Why take the risk?"

Another set of barriers to Medicaid participation related to applying for benefits. Respondents reported that sometimes immigrants went to welfare offices and were told that they were ineligible or that they should go get a job, even though an actual application or eligibility determination was not completed. In some cases, a receptionist or security guard turned the immigrants away, rather than the caseworker. Some of these policies may be an element of welfare "diversion" policies that were not aimed at immigrants *per se,* but at discouraging people from applying to welfare programs altogether.[6] However, advocates also cited examples in which caseworkers incorrectly denied eligibility because they misunderstood the complicated immigrant-related eligibility rules. Further, foreign-language applications or interpreters were often lacking, or if available, limited to certain languages (Spanish translations are more common than other translations). There were also problems with rude or insensitive caseworkers and excessive documentation requirements; complaints often voiced by native citizen applicants as well.

Some communities have established, or were considering, policies to reduce welfare fraud, but advocates were concerned that it might enhance immigrants' fears and even further discourage program participation. Los Angeles requires that welfare recipients be fingerprinted and New York City was considering a similar policy. In addition, Los Angeles has conducted pilot tests of sending inspectors to welfare recipients' homes (based on a policy adopted by nearby San Diego), but were unable to extend this policy more widely. While those policies were not aimed at immigrants alone, the contributed to immigrants' unease with public programs, including Medicaid.

Finally, during our site visits we heard a few concerns arising from the recently implemented Affidavits of Support (see box), relating to issues of sponsor liability and deeming. One community group representative told us about an African immigrant's struggle to decide whether to encourage his immigrant father (whom he had sponsored) to get Medicaid coverage for an expensive operation that he needed. He ultimately decided that he could not afford the potential Medicaid liability and sent his father back home.

Outstationed eligibility workers (Medicaid eligibility staff posted in settings like hospitals and health clinics) appeared to be an important application venue for immigrants, rather than welfare offices. In many cases, the immigrants came directly for care at the health facility and were then referred to the eligibility workers, but we also heard that clients viewed the outstationed workers as friendlier and more accessible. Los Angeles, especially, had made extensive use of outstationed eligibility staff. Maloy, et al. (2000) also reported that outstationed staff were important.

---

[6]One of the most visible examples occurred in New York City. As part of its welfare reform effort, some welfare offices were converted to job centers. At these centers, people applying for benefits were strongly discouraged from getting welfare. Even if they wanted to apply for Medicaid or food stamps, they were told they must return another day. This policy, later overturned due to a lawsuit, was not aimed at immigrants alone, but was part of a broader "work first" diversion strategy.

What is the Affidavit of Support?

As required by law, in December 1997 the INS issued a new Affidavit of Support, which stiffened responsibilities for those who are sponsoring immigrants (principally family members) as new entrants. For those sponsoring immigrants after that time, three new requirements apply: (1) The sponsor or sponsor's household must have an income level greater than 125 percent of poverty. (2) Sponsors' income may be "deemed available" as part of the immigrants' income in the determination of eligibility for means-tested public benefits, like Medicaid. This requirement will greatly reduce the number of immigrants who will be determined income-eligible, even after the five-year bar on eligibility imposed by PRWORA has expired. (3) Sponsors may be financially liable to repay expenditures for certain public assistance provided to the immigrants. For example, if a sponsored immigrant child participates in S-CHIP after the five-year bar, the state may bill the child's sponsor for the S-CHIP expenses incurred.

Since the second and third provisions are primarily applicable after the end of an immigrant's five-year bar on eligibility, they will not be relevant until December 2002, when the first people entering after December 1997 have been in the U.S. for five years. There is little explicit federal guidance on these issues yet. Thus, the details about how they will be implemented and who will be affected are not clear.

The affidavit does not apply after immigrants naturalize, or have worked in the U.S. for 40 or more Social Security quarters (usually ten years of work or are spouses or children of such workers). These rules do not apply for those without sponsors, such as refugees, those entering under employment preferences or diversity immigrants.

Medicaid for Pregnant Women. An important aspect of Medicaid eligibility for immigrants relates to pregnant women. Under PRWORA, noncitizens, including undocumented aliens and those who entered after August 1996, are eligible for emergency Medicaid benefits, including childbirth and delivery, but not prenatal care. This specific exclusion is troubling because of the importance of adequate prenatal care in assuring healthy birth outcomes.

New York provides prenatal care more broadly because of the lawsuit *Lewis v. Grinker.* In Los Angeles, some providers circumvented Medicaid restrictions on prenatal care for undocumented women by enrolling them under "presumptive eligibility" provisions that could last for six months until childbirth was imminent. In Houston, public and nonprofit clinics provided prenatal care for undocumented alien women until their last three weeks, at which point they could be enrolled in emergency Medicaid. Some providers acknowledged that they were highly motivated to provide prenatal or maternity care because of relatively high Medicaid reimbursement rates, so that there was often competition for pregnant immigrants.

State Children's Health Insurance Programs. State policies regarding S-CHIP programs have been quite different. In planning their S-CHIP programs, states became aware that a large portion of the uninsured children were Hispanic and the children of immigrants, and sought to find better ways to cover these children. Although the same restrictions on the use of federal

funds for noncitizens apply in S-CHIP as in Medicaid, all four states created state-funded add-ons to cover post-enactment noncitizen children in S-CHIP, except that Florida recently decided it would limit the number of noncitizen children that will be served in the future, as shown in Table 2.[7]

Table 2
Summary of Medicaid and S-CHIP Eligibility for Noncitizen Children, as of August 2000

	California	Florida	New York	Texas
Covers post-enactment noncitizen children in Medicaid using state funds	Yes	No	No	No
Covers post-enactment noncitizen children in separate S-CHIP program using state funds	Yes*	No longer**	Yes	Yes
Income eligibility criteria for Medicaid by age:				
Infants	200% FPL	200% FPL	185% FPL	185% FPL
Ages 1–5	133%	133%	133%	133%
Ages 6–16	100%	100%	100%	100%
Ages 17 and older	100%	100%	100%	100%
Maximum income eligibility criteria for separate S-CHIP program by age***:				
Infants	250% FPL	200% FPL	250% FPL	200% FPL
Ages 1–5	250%	200%	250%	200%
Ages 6–16	250%	200%	250%	200%
Ages 17 and older	250%	200%	250%	200%

FPL = federal poverty level; 100% of the poverty level for a family of three is $14,150 in 2000.

* California permits enrolling these immigrants in S-CHIP on an annual basis, requiring renewal each year.

** In June 2000, Florida decided to stop adding additional post-enactment immigrant children to its Healthy Kids program, but it will continue to serve those already participating. In addition, as immigrant children exit the program, their slots may be filled by other immigrant children, whose names are kept on a waiting list. Florida has two separate S-CHIP programs: MediKids for children 0–4 years and Healthy Kids for children 5 and older.

*** In most cases, the Medicaid income limit forms the bottom boundary of income eligibility for S-CHIP programs. However, in cases of noncitizen children not eligible for Medicaid, children with incomes in the Medicaid range may be eligible for S-CHIP instead.

[7] States have the option of using federal S-CHIP funds to expand Medicaid, to create a separate state program or both. All four of these states have taken a combination approach, with small Medicaid expansions for child eligibility and larger expansions in the separate programs. In this section, we refer to the separate programs as their S-CHIP programs, in contrast to their Medicaid expansions.

States tended to be more generous with respect to immigrant participation by adding state-funded add-ons to their S-CHIP programs rather than their Medicaid programs, except for California which serves post-enactment immigrant children by state-funded add-ons to both Medicaid and S-CHIP. The other three states' S-CHIP policies are more generous (with respect to immigrant child eligibility) than their Medicaid policies. New York and Florida had state-funded programs that predated S-CHIP (Child Health Plus in New York and Healthy Kids in Florida) that provided insurance regardless of immigration status and the states maintained the same rules under S-CHIP, even if federal matching funds were not available. However, Florida recently changed its rule, so that it will not accept more post-enactment noncitizen children into Healthy Families (those not eligible for federal match), but it will continue to serve immigrant children already in the program. This past year, Texas elected to cover post-enactment immigrant children in a state-funded add-on to its S-CHIP program, financed with funds from its tobacco settlement. In these states, even though some post-enactment immigrant children were barred from Medicaid, the children could still be eligible for S-CHIP.

All four states have developed joint applications for children that can be used for either Medicaid or S-CHIP enrollment (these can at least be used for an initial Medicaid screening if not full eligibility determination).[8] Each state's S-CHIP application still asks whether the children are citizens or legal residents, but notes that children may still be eligible even if they are not citizens. The states have tried to avoid including questions in their S-CHIP applications that might create undue worries.

The size of the state's S-CHIP programs vary. New York and Florida have well-established programs and many children have joined. California has struggled with efforts to sign up children and made substantial progress. Texas' main S-CHIP program began service in May 2000 and is still small but growing.

An important attribute of the S-CHIP programs is that there have been active outreach campaigns conducted in multiple languages, often incorporating assistance from community organizations, to encourage Hispanic, Asian and other ethnic children to join the S-CHIP programs, even when their parents are noncitizens. Much of the "public charge" education in the past year has been related to S-CHIP outreach efforts. In contrast, there has been less outreach for Medicaid enrollment.

[8] S-CHIP policies and application forms are current as of August 2000.

D. Immigrants' Access to Health Services

Survey data indicate that immigrants often have no regular source of health care and depend on clinics and hospital outpatient departments for care. As a rule, noncitizens receive substantially less medical and dental care than native citizens, even after accounting for differences in income, employment and health status (Brown, et al. 1999; Ku and Matani 2001). Many factors affect immigrants' ability to use health services, but financial access, particularly whether they have insurance, is especially important. Inability to pay for health care is one of the most fundamental barriers to health care. The previous section discussed immigrants' use of Medicaid and S-CHIP. In this section, we focus on how well immigrants (particularly those with Medicaid or who are uninsured) can access and use health services. First, we discuss some general issues, then focus on problems of the uninsured and then the new challenges posed by Medicaid managed care.

General Access Issues. Aside from financial factors, the most important factor for immigrants' health care access is language access, such as availability of bilingual/multilingual staff, translated materials and interpreter services. Immigrants, particularly those newly arrived, often have limited or no English proficiency. Miscommunication with doctors or nurses can lead to medical errors in diagnosis, treatment, or in patients' understanding of what to do. One recent study found that language barriers were as powerful as lack of insurance in predicting Latinos' use of health services (Derose and Baker 2000). Another recent study by researchers at the Agency for Health Care Quality found that Hispanic children had much lower access to medical care than white children, but that these gaps became negligible when their parents' English language skills were comparable to white parents, suggesting the critical role of language and interpretation in immigrants' health care access (Weinick and Strauss 2000). In addition, one survey found that many Latinos believe they were treated rudely or inappropriately by health caregivers because of the way they spoke English (The Henry J. Kaiser Family Foundation 1999). Patients may delay or avoid care if they do not think they will be understood. Immigrants often have to bring English-speaking friends or family (in many cases, their children) to the doctor's office to help translate. Relying on family or friends, however, is potentially embarrassing, error prone and often infeasible.

Although many providers make substantial efforts to provide translation and interpretation services (see Section E), language access was a persistent barrier in each city. In Los Angeles, Miami and Houston, many physicians, nurses and other health professionals speak Spanish, but the large number of Spanish-speaking patients still taxes the system. Further, some providers mentioned that many patients are poorly educated and illiterate even in Spanish, so they cannot comprehend written materials. Translations are more problematic for less common languages, including Vietnamese, Korean, Chinese, Russian and Creole. Longstanding federal civil rights policies are that health care providers must ensure language capacity for patients (Office of Civil Rights 2000), but it is clear that language problems are encountered on a daily basis.

Immigrants, particularly those newly arrived, are often isolated in their communities and do not always know how to access community resources. Some health care providers believed that immigrants need more intensive outreach efforts, often involving door-to-door or neighborhood-

level campaigns, particularly for preventive services and prenatal care. In Houston, a mobile health van was able to screen people for health problems in their neighborhoods and was successful in drawing out many immigrants.

Access for Uninsured Immigrants. More than half of low-income immigrants lack insurance. Unlike the general U.S. population, being uninsured is the norm, not the exception. Thus, immigrants seeking health care typically must be able to pay for health care out-of-pocket. Because of this bleak insurance profile, many immigrant families are essentially unable to obtain care in private doctors' offices. Instead, they (1) rely on safety net providers, including public and nonprofit clinics and hospitals, (2) use alternative, sometimes underground, health care sources or (3) delay care or go without.

Safety net clinics and hospitals are critical sources of care for immigrants because they provide services for free or at discounted prices and because they are more likely to have multilingual staff. Survey data indicate that immigrants rely on clinics (as compared to private doctors' offices) far more than native citizens (Ku and Matani 2001).

Although public clinics and hospital outpatient departments were the dominant safety net providers of care for the uninsured in each city, many immigrants, particularly the undocumented, were wary of using government clinics or hospitals, although others use them routinely. A deeply-rooted fear is that government clinics or hospitals might report their presence to the INS, which could eventually lead to deportation. Even legal immigrants sometimes worried that government services might cause eventual problems because of "public charge" issues. One advocate noted that some immigrants came from countries with repressive governments and seek to avoid any entanglement with the government. These fears are sufficiently serious that some immigrants even avoid using emergency rooms.

Immigrants' worries may be triggered by application forms for subsidized services at clinics or hospitals. To qualify for free or reduced-price care, prospective patients usually have to show they are eligible. The applications often ask for Social Security numbers (sometimes only for recordkeeping purposes) or ask explicitly about immigration status, which can create a chilling effect among both legal and illegal immigrants. Even if the patient is a U.S.-born child, information about parents' status is sometimes requested. If they do not complete the applications or are unable to present necessary documentation, immigrants or their children must pay the full price for health care or be denied care.

Although all the county- and city-owned facilities had systems of free and sliding-scale fee care for low-income uninsured patients, undocumented aliens (and temporary status immigrants, like visa holders) often were not eligible for subsidized care, although much has changed since the date of our visits. Sometimes immigrant restrictions were related to requirements that patients needed to be residents of the county, which had been interpreted so as to effectively bar undocumented aliens or visa holders from eligibility. For example, at the Harris County Hospital District in Houston, undocumented aliens and visa holders were barred from getting a "Gold Card" for free or discounted services and had to pay full charges for care (perhaps $100

for a specialty clinic visit), while legal immigrants or native citizens got care for free if their incomes were below the poverty level or with modest copayments ($2 to $5 per visit) with incomes below 200 percent of poverty.[9] Similar problems were voiced about the inability of undocumented aliens to get free or discounted services under Miami's Public Health Trust-funded services at Jackson Memorial Hospital, but the policies were recently changed in August 2000. After Florida Legal Services expressed its concerns, procedures were modified so that undocumented aliens who are county residents may obtain subsidized services.

In other areas there were similar systems, but the consequences for undocumented aliens were less onerous and exclusionary. For example, the Los Angeles County Department of Health Services facilities implemented a system in which a person could get care for $35 per visit with "no questions asked." This plan was more affordable and less intimidating since it allowed immigrants to avoid admitting that they were undocumented.[10] In addition, it was possible to arrange for payment on a credit basis.

In general, the nonprofit clinics (including relatively large federally-funded community health centers and small charity-funded free clinics) were viewed as more accessible to immigrants, even though they had more limited patient capacity and often had fewer services (e.g., less specialty care) than the public system. They usually had simpler applications and ask fewer questions about immigrant status. Most clinic administrators felt such questions were not necessary information and might intimidate some patients. As an example, an administrator at a nonprofit clinic in Los Angeles explained that the clinic did not normally ask about citizenship status, but there was a periodic survey of patients' legal status for statistical purposes. After this survey, one patient asked to have his appointment rescheduled for "a day when the INS was not there."

Some nonprofit clinics appealed to immigrants because of ethnic or religious affiliations. For example, Catholic charity-owned clinics often catered to Hispanic patients and were viewed more positively by them, just as there were Asian and Caribbean clinics focused on those ethnic groups. Most nonprofit clinics sought to have good community relations and try to customize their services to the cultural/ethnic needs of their neighborhoods.

It was somewhat more difficult for immigrants to get hospital inpatient care if they were uninsured. Public clinics were affiliated with the public hospitals and typically were able to get their patients admitted at those hospitals. Nonprofit clinics had more difficulties in finding nonprofit or public hospitals that would admit their uninsured patients.

Uninsured immigrants also get care from other health care sources that offer fewer hassles and low prices. The sources include private doctors and dentists, often foreign-born themselves, who set up practices in their ethnic communities; many will provide a limited amount of free or

---

[9]The rules at Harris County Hospital District were complicated and a subject of some controversy within the community. In December 2000, the new executive for the Harris County Hospital District announced that he would formally propose that undocumented aliens be eligible for Gold Card status, provided they could document county residency, commenting that this policy had been successful in San Antonio, Texas. As noted above, an undocumented women could get prenatal care at the city or county health department clinics, get emergency Medicaid just as she was ready to deliver and then get Medicaid-subsidized delivery services at the hospital district.

[10]Aliens can also have problems providing documentation of income or residency if they are not present legally or are not working legally.

reduced-price care on a pro bono basis as a community service. There are a number of for-profit "clinicas," particularly in Los Angeles, that primarily serve uninsured immigrants on a cash or credit payment basis. It was beyond the scope of this study to review these clinics thoroughly, but we heard that they typically had low prices and relatively high patient volume. Other providers alluded that many were "mills" with poor quality care and unlicensed staff, but we have no direct evidence to support this. Some immigrants go to "underground" clinics to obtain medical services from unlicensed providers. The underground providers may offer traditional ethnic remedies or may be Western-style doctors not licensed to practice in the U.S. A Chinatown clinic that catered to immigrants was recently shut down in New York City because of practicing medicine without a license (Kershaw 2000). A small share of immigrants go abroad for medical care (e.g., returning to Mexico) particularly for operations that might be costly or require additional family support.

Some immigrants avoid or delay seeking medical care. Health care providers said that low-income patients often arrived with relatively advanced stages of disease because they had avoided preventive or primary care, due to financial barriers, ignorance or other reasons. Another way that immigrants may be able to delay or avoid care is purchasing medications without prescriptions or by using traditional folk or herbal remedies. Since many pharmaceuticals (e.g., antibiotics, contraceptives, etc.) are sold over-the-counter in foreign countries, including Mexico, many immigrants rely on medications brought in from abroad. In many cases, these drugs are sold under-the-table at flea markets or even grocery stores. Los Angeles had begun a crackdown on black market drug stores after one immigrant's child died after taking inappropriate medications (Warren 1999). Residents also purchase—for their own use—prescription drugs abroad and bring them back to the United States, which is relatively easy for those in Los Angeles or Houston.[11] These practices can be hazardous if people take inappropriate medications or if the quality of the pharmaceuticals is not good. Finally, many immigrants use traditional folk or herbal remedies because of cultural familiarity and lack of access to "western" medicine.[12] Although there have been some local activities to crack down on underground medical or pharmacy services, local reaction has been mixed. Some believe that the immigrants are getting substandard care, but others feel that immigrants use these underground services because of affordability and cultural familiarity (Wong 2000, Steinhauer 2000).

Medicaid Managed Care. Even if they have insurance through Medicaid, immigrants face other problems getting health care. In each of the four sites, Medicaid was in the midst of a massive shift toward capitated managed care. Medicaid enrollees must select a managed care plan or, if they do not make a selection in a limited time period (2 weeks to a month), they are automatically assigned to a plan. Once in the plan, they must select a primary care physician or be assigned one.

There were a number of complaints about difficulties faced by immigrants, particularly those with limited English proficiency. Immigrants often could not read the managed care enrollment materials and were auto-assigned to health plans and providers with whom they were unfamiliar

[11]Under a new federal law, it is legal to bring prescription drugs into the United States in limited amounts, even if you do not have a prescription.

[12]Use of alternative forms of healing is not confined to immigrants; it is also common among native citizens.

and could not communicate due to language barriers. Materials were often available in Spanish, but it was hard to find materials in Vietnamese, Russian or Creole. Other communications problems resulted in further confusion. In Houston, for example, physicians were generally listed by name, rather than by location, causing problems for those knowing the name of the clinic, but not a specific doctor's name. Further, many physician directories did not note the languages the physicians or their staff spoke. These gaps made it hard for immigrants to complete the enrollment forms properly.

A more subtle and deeply rooted problem was that many immigrants found managed care too confusing. Most of the immigrants to the United States come from countries with state-run health systems where people simply go to the public clinic or hospital for care and health insurance per se is not relevant. Despite its many virtues, the American health care system is more complicated. The importance of health insurance is a difficult concept to many immigrants, inconsistent with their native experiences in how to get medical or dental care. Managed care systems, which require even more sophisticated navigation through a health care system, were yet harder to comprehend. One study found that barriers to care were generally more severe for Hispanics and Asians in managed care settings, which is consistent with the notion that immigrants have greater difficulties (Phillips, Mayer and Aday 2000).

E. Safety Net Providers' Organizational and Financial Responses

The changes in immigrants' Medicaid coverage could adversely affect many health care providers' balance sheets, particularly if they still provide care for them as uninsured patients. In each city, safety net providers were reporting declining Medicaid participation and revenue and increasing numbers of uninsured patients, creating financial pressures. As will be discussed below, it is not clear whether these changes are attributable to immigrant-related changes or other trends. In addition, in some of the cities, particularly Los Angeles and New York, alternative programs were helping to fill in the gaps that Medicaid was leaving. Despite providers' precarious status, we also heard that many were upgrading services for immigrants and developing innovative approaches to providing care.

Financing the Safety Net for Immigrants. The core components of the health care safety net in these cities were the local public hospitals and their affiliated clinics (Los Angeles County Dept. of Health Services, New York City Health and Hospitals Corporation, Jackson Memorial Hospital and the Harris County Hospital District). Each system reported that Medicaid caseloads and reimbursements were falling, while the number of uninsured patients was rising. The public systems, with the noteworthy exception of Miami's, were under serious financial strain. They were being propped up by a combination of revenues, including local taxes and Medicaid Disproportionate Share Hospital payments, and expenditure reductions through various budget-cutting operations. It is beyond the scope of this paper to provide a detailed analysis of the financial status of the safety net in these cities; recent reports on the local safety nets are available elsewhere (Norton and Lipson 1998; Los Angeles Dept. of Health Services 1999; Meyer et al. 1999; Hirschkorn 2000; Prinz 2000).

Immigrant-related Medicaid eligibility changes were just one of many forces that were affecting the public systems. Even more important were broader Medicaid caseload reductions (related to welfare reform), reductions in Medicaid patient volume and reimbursements due to Medicaid managed care and other factors, and wider competitive market forces that were leading to a reduction in inpatient services. In Houston, one of the responses to financial problems was the limitation of services for undocumented aliens at Harris County Hospital District. A few years ago local media reported that some foreign residents had flown in from abroad to get free medical care. This was viewed as an inappropriate use of county funds in a time of fiscal hardship, so the district curtailed eligibility for undocumented aliens and non-residents (although it now appears that undocumented aliens will be made eligible in the near future).

One consequence of the fiscal problems in the public systems was an increased effort to enroll people in Medicaid, so that there would be fewer uninsured patients. Los Angeles County undertook an unprecedented outreach campaign to sign up more than 100,000 people into Medicaid, as ordered by the county's board of supervisors. They focused on enrollment for Latinos, including immigrants. The other cities tended to focus more on S-CHIP enrollment, but there was a similar underlying motivation. Getting people insured would not only help those

individuals, but could reduce the burden of uncompensated care. Paradoxically, however, if providers were successful in helping patients enroll in Medicaid, they might "lose" patients who selected or were assigned to another provider under Medicaid managed care. Sometimes providers were "competing" for Medicaid or S-CHIP patients; this practice appeared to be particularly important in New York City.

Have changes in immigrants' Medicaid access affected the health care safety net? Analyses of data from New York Health and Hospitals Corporation indicate that public hospitals in high-immigrant areas of the city (compared to those in low-immigrant areas) had faster growth in their levels of bad debt and charity care, more growth in the number of uninsured inpatient discharges, an increase in emergency Medicaid hospitalizations and a lower decline in Medicaid inpatient discharges (New York Immigration Coalition 2000). The findings indicate that changes in insurance patterns of immigrants can affect the finances of these hospitals.

Our own analyses of Los Angeles County vital statistics data indicate that the number of Medicaid-financed births to foreign-born women fell by 19 percent from 1994 to 1997, roughly twice the drop in Medicaid births for U.S.-born mothers (Freilich, et al. 2001). Maternity hospitals with large immigrant patient caseloads had particularly large reductions in revenues for Medicaid deliveries.

The effects of immigrant's Medicaid loss in Los Angeles was more mixed for nonprofit facilities, such as community health centers. One multicultural clinic in Los Angeles had major financial losses in the past two years (largely because of an insufficient number of Medicaid managed care patients), but others appeared to be faring well. A large community health center and a nonprofit hospital noticed steep reductions in patient caseloads after Proposition 187 was passed, but felt that utilization had climbed back since then. Some clinic administrators noted that they are always backlogged and cannot serve all those who want services, so that changes in eligibility or fears about health care simply changed the length of their waiting lists, not the actual volume of care.

In Los Angeles and New York, loss of Medicaid revenue was partly offset by alternative programs. Under Los Angeles' Public Private Partnership (PPP) program, the county allocates funds to private (mostly nonprofit) clinics to give primary care services to low-income uninsured people. Clinic administrators believed that many of the PPP patients were immigrants who were scared away from Medicaid (or not eligible). PPP applications were generally quite simple and did not ask about immigrant status. Although these community clinics were losing Medicaid revenue, they were getting PPP revenue as a partial replacement.

In New York, Child Health Plus was serving an important role in filling gaps left by Medicaid. First, immigrant children, including post-enactment immigrants, were eligible for the program and there was relatively active recruitment of participants. New York's program was well-established and easily the largest in the country; 1999 enrollment levels were more than double California's similar program (Health Care Financing Administration 2000). Many immigrants' children who might have avoided Medicaid were in Child Health Plus instead. Although clinics

were losing Medicaid revenue, they were gaining S-CHIP funds. The situation appeared similar in Miami, where there was also a large, established S-CHIP program, but we heard less about this.[13] Houston had just begun to implement its S-CHIP program, so it was too early to tell.

Language Access. Maintaining bilingual staff and translation facilities is a common challenge faced by providers, but there were many efforts to broaden language access. Bilingual or multilingual physicians and nurses are considered assets and some facilities pay wage differentials for those with language skills. Many health care providers were adding capacity in languages beyond Spanish: in Miami clinics were adding Creole, while in Houston many were adding Vietnamese. In Los Angeles and Houston, nonprofit immigrant organizations collaborated with local providers to supply interpreters for certain Asian or African languages. In New York, Medicaid managed care contracts had explicit requirements for language accessibility that led providers and managed care plans to develop translation capacities, such as use of the AT&T Language Line. One hospital system in Los Angeles prominently displayed pictures of their doctors along with the languages they spoke, to aid patients in selecting a primary care physician. In all four cities, we heard about use of the AT&T Language Line interpreter services, particularly to help with less common languages.[14] One clinic installed speaker phones to make it easier to include a third party interpreter in discussions.

Paying for interpretation services, however, is challenging. Medicaid, Medicare and private insurance often do not pay extra when an interpreter is needed.[15] One physician offered the sanguine comment that, while he believed in the importance of translations, it was hard to afford paying $40 to $50 for an interpreter when his Medicaid reimbursement might only be $10. One public hospital used some of its Medicaid Disproportionate Share Hospital (DSH) revenue to pay for more interpreters and related services. Other facilities viewed language skills as a necessary cost of business: if a provider is located in an area with a 50 percent Spanish-speaking population, it must have Spanish capabilities to attract enough patients. Another clinic noted that when it added a physician who spoke Vietnamese, the number of Vietnamese patients surged.

Special Projects. In each city, there were special health care projects designed specifically to meet the health care needs of immigrant or ethnic communities. Typically, these were started by a community organization or local hospital and supported by special grants from foundations or religious organizations. For example, a community organization in Brooklyn and the Lutheran Hospital system created the Caribbean American Family Health Center. In Los Angeles, a legal rights organization worked with other groups to develop a small insurance network for low-income immigrants in San Fernando Valley. A Catholic hospital in Houston developed a mobile health van to serve hard-to-reach populations, particularly immigrants. While these efforts generally could only serve a modest number of people and offer a limited range of services, they were signs of innovative community-based initiatives to help improve immigrants' health.

---

[13] However, since the date of our visit to Miami, the state has decided to stop admitting further post-enactment immigrant children in its S-CHIP program.

[14] The telephone service is not inexpensive and costs about $3 to $5 per minute. Some respondents complained about the quality of translations, while others seemed satisfied. Other firms provide similar services and some specialize in medical interpretation.

[15] Federal policy authorizes the use of Medicaid and S-CHIP funds by states in paying for oral or written translation administrative services and for services provided to Medicaid and S-CHIP patients, but it is not clear how often states use these options. (Westmoreland 2000). Providers report that special supplemental payments for interpretation or translation services are not typically made available, however.

F. Factors Shaping the Policy Responses in the Four Cities

Although many aspects of the recent policies for immigrants were federal in nature (PRWORA, IIRIRA, and the interpretation of public charge status), the implications differed in each city. In comparing the circumstances of immigrants and health care providers in the four cities, three differences stood out. One is the role of policy vs. perception. The second is the role of state and local checks and balances. The final is the importance of cost-shifting and the underlying generosity of each municipality's health care system.

Policy vs. Perception. Immigration was the subject of vigorous public debate in California, particularly under former Governor Wilson. This very visible debate sensitized some immigrants to believe that they were not welcome and should avoid government support. In turn, this meant that the "chilling effect" appeared greatest in Los Angeles. In New York City, Houston and Miami, the political rhetoric was more tolerant and inclusive of immigrants and ethnic minorities and the policy debates were less visible, so immigrants had fewer fears.

And yet, California enacted the most generous policies towards immigrants in the wake of PRWORA, supporting Medicaid and S-CHIP eligibility for post-enactment immigrants with state funds. New York, Florida and Texas supported post-enactment immigrants only in their S-CHIP programs, but not Medicaid. One possible explanation for this paradox is that the vigorous debate about immigration could have strengthened immigrant advocates in that state, so that they could press harder for immigrants' health benefits in California, while it was more difficult for immigrant advocates in other states to muster political support to get broader policies.

Does policy or perception affect immigrants' Medicaid participation more? In the absence of good data, we have no definitive answer, but our case studies provide some insights. Perceptions and fears can quickly affect participation in Medicaid and use of government programs. If people believe that they might be punished for using public benefits or that they are no longer eligible, there can be a rapid reduction in participation. On the other hand, perceptions have a limited lifetime. With time, public education efforts about the public charge issue, other public outreach, and the realization that neighbors are joining Medicaid or S-CHIP without negative consequences will encourage people to join Medicaid.

The actual policies also affect participation, but may be more gradual in nature, particularly since PRWORA's policies pertain to the ever-increasing number of immigrants who entered after August 1996. Thus, immigrants' ability to be insured through Medicaid will gradually decline in Texas, Florida and New York because they just will not be eligible. While perceptions can have an important initial effect on participation, the actual policies ought to matter more in the long run.

Checks and Balances. Litigation also shaped the policy actions and implementation differentially. New York and California were more litigious and had more organized advocacy communities; their policies were shaped by legal challenges that blocked, delayed or modified executive and legislation actions. On one hand, litigation ultimately led to more generous policies in those two states, but it also kept the pot boiling, so that there might have been more

confusion about the actual policies. In Texas and Florida, administrators and legislators were relatively more powerful because the advocacy and legal services community was smaller. But even in these communities, local advocates helped motivate the local hospital districts to provide subsidized care to needy undocumented aliens.

Another important check and balance is the separation of federal, state and local authorities. Although federal authority restricts Medicaid and S-CHIP benefits for recent immigrants, states opted to use state funds to cover the difference in S-CHIP programs and California also covered immigrants' Medicaid benefits. Local governments sometimes took special efforts to help immigrants both because they are responsible for financing their local public hospital systems and because of sensitivity to local political constituencies. For example, Los Angeles was particularly aggressive in trying to increase Medicaid enrollment and defusing concerns about the public charge issue, partly because of its concern about uncompensated care burdens.

Cost-Shifting and Underlying Generosity. One view of the effect of PRWORA is that it shifted costs and responsibilities away from the federal government and toward state and local governments and nonprofit health care providers. An impetus for the immigrant provisions of the law was to reduce federal spending for public assistance, including Medicaid. As noted earlier, states had the option to continue to provide benefits to post-enactment immigrants, but would not receive federal matching payments (except for emergency medical care). All four states assumed at least some additional financial burden by providing coverage to post-enactment immigrant children in S-CHIP; California took on even greater costs by covering immigrants of all ages in Medicaid.

To the extent that immigrants lost Medicaid coverage and became uninsured, the safety net health care providers, which include public and nonprofit hospitals and clinics, faced greater uncompensated care burdens. Thus, many of the costs of care shifted down to local governments and charitable organizations. The extent to which low-income uninsured immigrants can get free or reduced-price health care is largely a function of the underlying generosity of each local area's health care safety net. Our observations indicated that New York City's and Los Angeles' safety nets have traditionally been broader and somewhat more generous than Houston's or Miami's. This is partly because of policy choices, as well as differences in relative wealth and fiscal capacity of the four jurisdictions.

Although Los Angeles County had serious financial problems a few years ago, they maintained a relatively strong commitment to care for immigrants. Their responsibility was made easier because the state continued to provide Medicaid for post-enactment immigrants and because of the federal demonstration waiver project that created the Public-Private Partnership program. New York also had a very broad system of public hospitals and clinics, as well as a variety of nonprofit facilities. The availability of Child Health Plus for immigrant children also helped both patients and providers. Miami and Houston had substantial public hospital safety nets, where low-income legal immigrants could get uncompensated care at free or reduced prices, but the safety net outside those systems was less developed. To the extent that federal or state funds were not available, the local health care safety nets became more important and faced higher demands to provide care for low-income immigrants.

G. Conclusions

Even before the passage of PRWORA, immigrants' access to health care was precarious. The withdrawal of federal Medicaid coverage under the welfare reform law and related policy changes exacerbated the difficulties of low-income immigrants in these four cities. Immigrants have adapted to the loss of Medicaid coverage through a variety of imperfect strategies, including avoiding or delaying care, seeking alternative forms of health care and, most important, turning to safety net public and nonprofit clinics and hospitals that will help low-income uninsured people.

The effects of the loss of federal Medicaid support were cushioned, at least in part, by state and local responses to provide additional aid to immigrants. In each area, states elected to provide at least some additional coverage to post-enactment immigrant children under their S-CHIP programs using state funds. California went well beyond that standard and continued to offer state-funded insurance to all those who lost federal eligibility for Medicaid or S-CHIP. In some areas, outreach campaigns were encouraging ethnic minority children and children of immigrants to participate in S-CHIP programs. In the local areas, safety net providers rolled up their sleeves and filled in at least part of the gap in care for uninsured immigrants as part of their commitment to serve the needy. Indeed, in each community, a handful of providers and community groups were more sensitive to the language and cultural needs of immigrants and were developing innovative approaches to improve the quality of medical and outreach services for ethnic minorities.

While states and local governments and safety net providers have filled in much of the gap in health care services caused by the loss of Medicaid eligibility for immigrants, it is not clear whether these efforts can be sustained, much less strengthened. The number of immigrants admitted since 1996 will rise over time and the attendant costs to state and local governments and charitable providers will inexorably rise. Moreover, many states are beginning to report slowdowns in their economies after years of economic growth; this could increase the demand for Medicaid and other public expenditures while lowering state and local revenues.

While federal and state policy debates about the funding of Medicaid services for immigrants will probably continue, it is important to remember that there are other issues that must continue to be addressed concerning immigrants' access to care and the quality of care received. Providers, advocates and government officials particularly stressed the importance of improved language and outreach services to help immigrants navigate through the complex U.S. health care system and to help them communicate better with doctors, nurses and other health care providers.

REFERENCES

Brown, E.R., Wyn, R., and Ojeda, V. (1999). "Access to Health Insurance and Health Care for Children in Immigrant Families." UCLA Center for Health Policy Research, June (available at www.healthpolicy.ucla.edu).

DeRose, K. and Baker, D. (2000). "Limited English Proficiency and Latinos' Use of Physician Services," Medical Care Research and Review, 57(1): 76–91.

Feld, P. and Power, B. (2000). "Immigrant's Access to Health Care After Welfare Reform: Findings from Focus Groups in Four Cities," Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November.

Fix, M., and Passel, J. (1999). "Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994–97." Washington, DC: Urban Institute, March 1999 (available at www.urban.org/immig/trends.html).

Freilich, A., Ku, L, Fix, M. and Miller, G. (2001 forthcoming). "The Health Care Safety Net for Immigrants in Los Angeles and New York City: Effects of Recent Policy Changes." Washington, DC: Urban Institute.

Health Care Financing Administration. (2000). "The State Children's Health Insurance Program Annual Enrollment Report: October 1, 1998–September 30, 1999."

Hirschkorn, C., et al. (1999). "Miami: Market Calm, But Change on the Horizon." Community Report No. 8. Washington, DC: Center for Studying Health Systems Change. Spring.

Holahan, J., Ku, L. and Pohl, M. (2001). "Is Immigration Responsible for the Growth in the Number of Uninsured People?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured, forthcoming.

Kaiser Family Foundation. (1999). "Race, Ethnicity and Medical Care: A Survey of Public Perceptions and Experience." Menlo Park, CA.

Kershaw, S. (2000) "City Shuts Unlicensed Clinic Catering to Chinese Immigrants." New York Times, Aug. 17.

Ku, L. and Blaney, S. (2000). "Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage," Washington, DC: Center on Budget and Policy Priorities, Oct. 10. (available at www.cbpp.org/10-4-00health.pdf).

Ku, L., and Matani, S. (2001). "Left Out: Immigrants' Access to Health Care and Insurance," Health Affairs, 20(1): 247–256.

Lewin, M., and Altman, S., editors. (2000). America's Health Care Safety Net: Intact but Endangered. Institute of Medicine. Washington, DC: National Academy Press.

Long, S., and Zuckerman, S. (1999). "Urban Health Care in Transition: Facing the Challenge in Los Angeles County." Health Care Financing Review, 20(1):45–58.

Los Angeles County Department of Health Services. (1999). "Medicaid Demonstration Project Annual Report: Fiscal Year 1997/98." February.

Maloy, K, Darnell, J., Nolan, L., Kenney, K., and Cyprien, K. (2000). "Effect of the 1996 Welfare and Immigration Reform Laws on Immigrants' Ability and Willingness to Access Medicaid and Health Care Services: Findings from Four Metropolitan Sites." Center for Health Services Research and Policy, George Washington Univ., May.

Meyer, J., Legnini, M., Fatula, E., and Stepnick, S. (1999). "The Role of Local Governments in Financing Safety Net Hospitals: Houston, Oakland, and Miami." Assessing the New Federalism Occasional Paper 25, Washington, DC: Urban Institute. June.

New York Immigration Coalition. (2000). "Welfare Reform and Health Care: The Wrong Prescription for Immigrants." New York City, November.

Norton, S., and Lipson, D. (1998). "Portraits of the Safety Net: The Market, Policy Environment and Safety Net Response." Assessing the New Federalism Occasional Paper 19, Washington, DC: Urban Institute. November.

Office of Civil Rights, Dept. of Health and Human Services. (2000). "Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency." Federal Register 65(169): 52762–52774, Aug. 30.

Phillips, K., Mayer, M. and Aday, L.A. (2000). "Barriers to Care Among Racial/Ethnic Groups Under Managed Care." Health Affairs, 19(4):65–75.

Prinz, T., Haslanger, K., DeLia, D., Fass, S., Salit, S., Cantor, J. (2000). "Hospital Markets, Policy Change and Access to Care for Low-Income Populations in New York." New York: United Hospital Fund.

Rajan, S. (1998). "Publicly Subsidized Health Insurance: A Typology of State Approaches." Health Affairs 17(3): 101–17.

Schlosberg, C., and Wiley, D. (1998). "The Impact of INS Public Charge Determinations on Immigrant Access to Health Care." National Health Law Program and National Immigration Law Center, May. (available at www.healthlaw.org/pubs/19980522publiccharge.html).

Steinhauer, J. "For Some New York Immigrants, a Vast Alternative Health Care System, Underground." New York Times, August 20, 2000.

Viglucci, A. (2000). "Clinics Accused of Immigrant Bias." Miami Herald, Aug. 13.

Warren, P. (1999). "Baby's Death Puts Focus on Immigrants' Health Access." Los Angeles Times, Feb. 26.

Weinick, R. and Krauss, N. (2000). "Racial and Ethnic Differences in Children's Access to Care." American Journal of Public Health, 90(11):1771–74, Nov.

Westmoreland, T. (2000). "Dear State Medicaid Director Letter about Individuals with Limited English Proficiency." Health Care Financing Administration, Aug. 31, 2000.

Wong, E. (2000), "Chinese Immigrants Say Clinics Fill a Need for Inexpensive Care." New York Times, Aug. 17.

Zimmermann, W., and Fix, M. (1998). "Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County." Urban Institute, July (available at www.urban.org/immig/lacounty.html).

Zimmermann, W., and Tumlin, K. (1999). "Patchwork Policies: State Assistance for Immigrants Under Welfare Reform." Assessing the New Federalism Occasional Paper No. 24, Washington, DC: The Urban Institute.

1450 G Street NW, Suite 250, Washington, DC 20005
Phone: 202-347-5270, *Fax:* 202-347-5274
Web Site: www.kff.org

Additional free copies of this publication (#2227) are available on our website or by calling our publications request line at 800-656-4533.

BEST COPY AVAILABLE